National Association of
Children's Hospitals

Champions for Children's Health

N · A · C · H

October 31, 2011

Sarah Delone and Laurie McWright
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Shareen S. Pflanz
CC:PA:LPD:PR (REG–131491–10)
Courier's Desk, Internal Revenue Service
1111 Constitution Avenue, NW.
Washington, DC 20224

RE:
REG-131491-10; Health Insurance Premium Tax Credit; Notice of Proposed Rulemaking

CMS-2349-P; Medicaid Program; Eligibility Changes Under the Affordable Care Act; Proposed Rule

CMS-9974-P; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers; Proposed Rule

Dear Ms. Delone, McWright and Pflanz:

On behalf of 221 member children's hospitals across the country, the National Association of Children's Hospitals (N.A.C.H.) appreciates the opportunity to comment on the above-referenced Proposed Rules and Notice of Proposed Rulemaking (NPRM) promulgated by the Departments of Health and Human Services (HHS) and Treasury.

Children's hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services. Though children's hospitals account for only 5 percent of hospitals in the United States, they care for 47 percent of all children admitted to a hospital. Children's hospitals also provide almost all of the care for children with cancer, cardiac conditions, cystic fibrosis and spina bifida. Children's hospitals are regional centers for children's health, providing care across large geographic areas and often serving children across state lines.

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Children's Hospitals & Related Institutions

We commend you for the provisions in the Proposed Rules that simplify and coordinate enrollment among the Exchange, Medicaid, and the Children's Health Insurance Program (CHIP). However, we are concerned that the Treasury NPRM sets forth a "family penalty," which will negatively impact the opportunity to access quality health insurance for significant numbers of children. The NPRM also ignores the challenge that "premium stacking" will create for families with children covered by the CHIP program. Finally, we believe it is critical that Treasury and HHS work together to address the needs of children in complex family situations before finalizing the NPRM and Proposed Rules. We look forward to continuing to work with you to ensure that children's coverage is protected.

Family Penalty. We have deep concerns about the "family penalty" provisions of the NPRM. These provisions exclude families with children (and other individuals) from subsidized Exchange coverage even when they lack affordable employer-based coverage. The family penalty issue arises because of Treasury's proposed definition of "minimum essential coverage," as set forth at 1.36B-2(c)(3)(v). Treasury has chosen to define affordable employer-based coverage by considering only the premium cost for self-only coverage, which must be less than 9.5 percent of a household's income. Self-only coverage, however, by definition provides coverage to only one member of the household (the employee), not to the dependents/children in the household. While an employer may offer family coverage, because premiums for family coverage are considerably higher than for individual coverage, many families with dependents will be treated as having access to affordable minimum essential coverage even though the insurance offered will be too expensive for the family to reasonably afford.

The policy result of the Treasury interpretation violates the intent of the Affordable Care Act and would impact the families of millions of children without affordable coverage.[1] Under the NPRM, however, an offer of family coverage at prices similar to those offered today will leave families worse off. Families will be locked out of Exchange subsidies, and the high cost of employer-sponsored coverage will either consume a large portion of their incomes or cause them to forego employer coverage. In many instances, children in these families may be able to secure coverage through Medicaid and CHIP if these programs remain strong and in place. However, not all children in affected families will have an alternative option, and even those who do may have parents who remain uninsured. When parents lack coverage, it affects the financial stability of their families and can directly affect the health and well-being of their children. Treasury's interpretation would create incentives for families to seek out employers that do not offer any coverage or work to encourage their current employers to cease offering coverage. To the extent that employers respond to the desires of these employees and cease to offer coverage, the purpose of the affordability test will be undermined.

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[1] See Matthew Buettgens and Genevieve M. Kenney, "Implications of Relying on a Single-Only Affordability Test for Families," Memo to Interested Parties, the Urban Institute, 6 May 2011.

In light of these serious issues, we urge Treasury to use the discretion it has under the ACA to adopt an alternative interpretation of the affordability test that is family-based and includes the cost of dependent coverage. Specifically, we urge Treasury to revise 1.36B-2(c)(3)(v) to make it clear that a family will be potentially eligible for subsidized exchange coverage if the cost of family-based insurance – not just single-only coverage -- exceeds 9.5 percent of income.

Impact on families with CHIP-eligible children. The proposed rules will leave many families with children facing a "double premium" if they happen to have a child eligible for CHIP (or, in some limited circumstances where premiums apply, Medicaid). The issue (sometimes known as the "premium stacking issue") arises from the statutory formula used to calculate the advance premium tax credit, which establishes a specific dollar amount that families are expected to contribute to their Exchange coverage without any variation allowed even if they also must pay CHIP premiums.

Unfortunately, the number of families subject to this type of "double premium" is likely to be significant. Estimates from the Urban Institute indicate that three out of four parents who are eligible for the Exchange will have one or more children who are eligible for CHIP or Medicaid and must enroll in these programs. It is unknown how many of these families must pay premiums to enroll their children in public coverage, but 30 states charge a premium or annual enrollment fee to children in CHIP, so this is a serious concern. While the fundamental issue arises from the statute, the proposed rules do not acknowledge the problem, nor do they provide states with any options or advice for addressing it.

If Treasury chooses instead to maintain its current definition, the practical effect of using the affordability test as proposed in the NPRM means that families will be forced to either: 1) pay a larger part of their income for coverage than similarly-situated families without an employer offer; or 2) leave children without coverage. Such a choice should not be a consequence of the Affordable Care Act, the clear intent of which is to provide affordable coverage to nearly everyone in the United States. A more comprehensive and accurate assessment of a family's premium obligations is consistent with the intent of the Affordable Care Act; would lead to more children having health coverage; and would be less disruptive to the employer-sponsored insurance market. Other solutions to lessen the burden on families of multiple premium costs should also be explored in the final rules, such as counting CHIP premiums in the tax credit calculation or modifying CHIP rules in some way to not penalize families with children in CHIP.

Enrollment Regulations. The undersigned organizations also appreciate this opportunity to comment on the Proposed Rules that set forth standards for eligibility determinations and enrollment procedures for insurance affordability programs. We commend HHS for proposing rules that create a "no-wrong door" and a simple, streamlined health care coverage eligibility and enrollment process that includes

application assistance and electronic verification of eligibility whenever possible. Specifically, we strongly support the following elements in CMS-2349-P (Medicaid Eligibility Changes):

- Single, streamlined application for all insurance affordability programs that can be completed online, by phone, in person, by mail, or by fax, and signed electronically
- Redetermination of eligibility using existing data available to the agency whenever possible, or otherwise by pre-populated forms that enrollees can reply to online, in person, by phone, by mail, or by fax without losing coverage
- The adoption of 12-month renewal periods, which has been a very successful policy for children
- An explicit option for states to accept self-attestation of eligibility criteria and conduct electronic data matching through a federal data hub linked to other federal agencies

In CMS-9974-P (Exchange Functions in the Individual Market), we strongly support the requirement that Exchanges and Medicaid and CHIP agencies coordinate their work so that applicants can enroll in the form of coverage for which they are eligible, regardless of the agency to which they initially submit their application. e also strongly support the following requirements:

- Exchanges may not duplicate eligibility and verification findings that have already been conducted by agencies administering Medicaid, CHIP
- Exchanges are expected to offer advance payments of premium tax credits to individuals seeking a determination of Medicaid eligibility on a basis other than income during the time that such a determination is being conducted
- Exchanges make an automatic annual redetermination based on a projected eligibility determination provided to enrollees in a notice if the individual does not return the notice within the time period allowed. However, we urge HHS to consider extending the period enrollees are given to return the notice based on the language in the corresponding Medicaid regulation, which allows this period to be longer than 30 days.

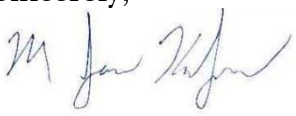
Implications for Children in Complex Family Situations. Finally, we urge the Departments to consider the impact of the NPRM and the Proposed Rules on children in complex family coverage situations. As many as 20 million children live in complex family arrangements that may create challenges in accessing insurance coverage.[2] While the ACA creates new opportunities for families to obtain coverage, we urge Treasury and HHS to pay special attention to ensure that children in complex household coverage circumstances do not fall through the cracks. In particular, many

[2] See McMorrow S, Kenney GM and Coyer C, "Addressing Coverage Challenges for Children Under the Affordable Care Act," the Urban Institute, May 26, 2011.

children live in families in which members may be eligible for different type of coverage (i.e. employer-sponsored insurance, public programs (in particular CHIP), or Exchange coverage with subsidies).Other children may live in families in which members have different immigration statuses. Still other children may live apart from at least one parent (such as with a single parent, non-married parents, grandparents, or other relatives). Each of these populations of children may be especially vulnerable to complex enrollment and tax rules and structures that may also be different from corresponding rules and structures under Medicaid and CHIP. These children should be protected and actively considered as the NPRM and Proposed Rules move toward finalization.

In conclusion, we appreciate this opportunity to share our views regarding the NPRM and the Proposed Rules. If we may provide further information or otherwise be of assistance, please contact Jan Kaplan at 703/797-6084 or jkaplan@nachri.org.

Sincerely,



M. James Kaufman
Vice President, Public Policy